DELINEATION OF CLINICAL PRIVILEGES - CARDIOVASCULAR SURGERY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

GENERAL: Cardiovascular surgical privileges involve pre-operative preparation, surgical management, and post-operative care of patients with diseases or defects of the heart, its vascular and conduction systems, great and peripheral vessels, and the pericardium.

NOTE: This document is to be used in conjunction with DA Form 5440-13, Delineation of Clinical Privileges - General Surgery.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

MINOR PROCEDURES

Requested	Approved	
		a. Subxyphoid window
		b. Cardioversion
		c. Insertion of arterial (e.g., Swan-Ganz) catheter
		d. Intra-aortic balloon pump insertion

VALVE SURGERY WITH CARDIOPULMONARY BYPASS

Requested	Approved	
		a. Commissurotomy
		b. Valve replacement
		c. Valve repair/ reconstruction
		d. Homograft/ autograft replacement

REPAIR OF CONGENITAL DEFECTS IN ADULTS

Requested	Approved	
		a. Atrial septal defects (primum, secundum)
		b. Ventricular septal defect
		c. Patent ductus arteriosus
		d. Sinus venosus
		e. Bicuspid aortic valve (commissurotomy, replacement)
		f. Aortic vascular anomalies (coarctation, rings, aberrancies)

CARDIAC REVASCULARIZATION (w/CPB, OPCAB, MIDCAB)

Requested	Approved	
		a. Coronary artery bypass
		b. Coronary artery endarterectomy

CONDUCTION SYSTEM CARDIAC SURGERY

Requested	Approved	
		a. Pacemaker (transvenous, epicardial)

CONDUCTION SYSTEM CARDIAC SURGERY *(Continued)*

Requested	Approved	
		b. AICD (transvenous, epicardial)
		c. Maze procedure
		d. WPW/ accessory pathway division
		e. Ventricular aneurysmorrhaphy with ablation

SURGERY OF THE GREAT AND PERIPHERAL VESSELS

Requested	Approved	
		a. Aortic replacement (ascending, descending)
		b. Aortic arch replacement
		c. Aortic root replacement
		d. Thoracoabdominal aneurysmorrhaphy
		e. Inominate/ carotid/ subclavian artery endarterectomy, repair, replacement, bypass
		f. Abdominal aortic/ iliac artery repair, replacement, bypass
		g. Femoral artery endarterectomy, repair, replacement, bypass

PULMONARY ARTERY SURGERY

Requested	Approved	
		a. Pulmonary embolectomy (acute)
		b. Pulmonary thromboendarterectomy
		c. Caval filter placement
		d. Vena cava repair/ interruption

TRANSPLANT

Requested	Approved	
		a. Heart

PERICARDIUM		
Requested	Approved	
		a. Pericardiectomy, pericardial window

CARDIORRHAPHY		
Requested	Approved	
		a. Excision of tumor
		b. Repair of trauma
		c. Repair ventricular septal defect
		d. Repair myocardial rupture
		e. Repair myocardial pseudoaneurysm

EXTRACORPOREAL CIRCULATORY SUPPORT		
Requested	Approved	
		a. Cardiopulmonary bypass (CPB)
		b. Veno-veno bypass
		c. Left atrial to descending aorta or femoral artery bypass
		d. Hypothermic circulatory arrest
		e. Insertion and management of ventricular assist devices (RVAD, LVAD)
		f. Extracorporeal membrane oxygenation (ECMO)
		g. Extracorporeal carbon dioxide (CO2) removal (ECCOOR/ ECO2R)

LASER PRIVILEGES

Requests for laser privileges may require the attendance at a formal laser training program(s), supporting documentation of training and experience, acknowledgement of receipt of the MTF laser policy and procedural guidance, and review and approval by appropriate MTF personnel with oversight responsibility for laser therapy. The necessary documentation in support of this request is attached.

Requested						
ARGON	ND:YAG	CO2				Approved
					a. Transmyocardial revascularization	
					c. Other *(Specify)*	

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

EVALUATION OF CLINICAL PRIVILEGES - CARDIOVASCULAR SURGERY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	MINOR PROCEDURES			
	a. Subxyphoid window			
	b. Cardioversion			
	c. Insertion of arterial (e.g., Swan-Ganz) catheter			
	d. Intra-aortic balloon pump insertion			
	VALVE SURGERY WITH CARDIOPULMONARY BYPASS			
	a. Commissurotomy			
	b. Valve replacement			
	c. Valve repair/ reconstruction			
	d. Homograft/ autograft replacement			
	REPAIR OF CONGENITAL DEFECTS IN ADULTS			
	a. Atrial septal defects (primum, secundum)			
	b. Ventricular septal defect			
	c. Patent ductus arteriosus			
	d. Sinus venosus			
	e. Bicuspid aortic valve (commissurotomy, replacement)			
	f. Aortic vascular anomalies (coarctation, rings, aberrancies)			
	CARDIAC REVASCULARIZATION (w/CPB, OPCAB, MIDCAB)			
	a. Coronary artery bypass			
	b. Coronary artery endarterectomy			
	CONDUCTION SYSTEM CARDIAC SURGERY			
	a. Pacemaker (transvenous, epicardial)			
	b. AICD (transvenous, epicardial)			
	c. Maze procedure			
	d. WPW/ accessory pathway division			
	e. Ventricular aneurysmorrhaphy with ablation			
	SURGERY OF THE GREAT AND PERIPHERAL VESSELS			
	a. Aortic replacement (ascending, descending)			
	b. Aortic arch replacement			
	c. Aortic root replacement			
	d. Thoracoabdominal aneurysmorrhaphy			
	e. Inominate/ carotid/ subclavian artery endarterectomy, repair, replacement, bypass			

CODE	SURGERY OF THE GREAT AND PERIPHERAL VESSELS *(Continued)*	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	f. Abdominal aortic/ iliac artery repair, replacement, bypass			
	g. Femoral artery endarterectomy, repair, replacement, bypass			
	PULMONARY ARTERY SURGERY			
	a. Pulmonary embolectomy (acute)			
	b. Pulmonary thromboendarterectomy			
	c. Caval filter placement			
	d. Vena cava repair/ interruption			
	TRANSPLANT			
	a. Heart			
	PERICARDIUM			
	a. Pericardiectomy, pericardial window			
	CARDIORRHAPHY			
	a. Excision of tumor			
	b. Repair of trauma			
	c. Repair ventricular septal defect			
	d. Repair myocardial rupture			
	e. Repair myocardial pseudoaneurysm			
	EXTRACORPOREAL CIRCULATORY SUPPORT			
	a. Cardiopulmonary bypass (CPB)			
	b. Veno-veno bypass			
	c. Left atrial to descending aorta or femoral artery bypass			
	d. Hypothermic circulatory arrest			
	e. Insertion and management of ventricular assist devices (RVAD, LVAD)			
	f. Extracorporeal membrane oxygenation (ECMO)			
	g. Extracorporeal carbon dioxide (CO2) removal (ECCOOR/ ECO2R)			
	LASER PRIVILEGES			
	a. Transmyocardial revascularization			
	c. Other *(Specify)*			

SECTION II - COMMENTS *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*